Report of the Review of Rules and Identification of Areas of Duplication, Vagueness, Ambiguity or Conflict for Implementation of the State Plan
As required by HB 381, Section 3(a)(2)

In all disability areas, the State Plan states that individual treatment plans, delivery of services and state and local policy shall operate utilizing the concepts of self-determination, recovery, person-centered, system of care and the integration of evidence based/best practices. Rules and service definitions among state and federal funding (block grants and Medicaid) currently support facility-based, medical, acute models of service delivery. They are not focused on outcomes, continuity of care or the supports and services needed for community based treatment or for long term disabilities. In order to make the massive revisions needed to implement the plan, making changes to rules or statutes in a piecemeal fashion will not be effective and can have unintended consequences. In addition, it should be recognized that this type of analysis and revision are technical, tedious and can not be completed quickly.

Listed below are areas identified through the development of the State Plan and feedback received from advocates, families, providers and state staff. As the State Plan is implemented and rules revised with input from consumers as well as other stakeholders, additional changes will be required in rules and statutes that are not noted below.

Rule Making Authority

- Authority and responsibility of rule making is spread over four (4) different Commissions, the DHHS Secretary and a separate public notice process for DMA. There is no central authority for making rules. Depending on the issue or the type of the provider, a rule may need to go through the DMA rulemaking process, DMH Commission, DSS Commission, Medical Care Commission or Secretary's authority for rule making. Coordination and consistency is more difficult when authority is spread over several places.

  The authority for establishing rules for client rights illustrates the ambiguity. G.S. 122C-121.1 says, "The Secretary shall….Adopt rules for the enforcement of client rights served by State Facilities, area authorities, county programs and providers." At the same time, 122C-60 says…"The Commission shall adopt rules…." on use of physical restraint, implement provisions of restraints, and seclusion, etc. However, restraint and seclusion is a part of the client rights rules, and adoption by the Secretary also applies.

  Many providers offer services that are regulated by the different Commissions. For example, an adult care home may be subject to rules established as a result of licensure, funding source or programmatic requirements that are subject to action by the Medical Care Commission, MH/DD/SA Commission, DSS Commission and the Secretary.

- During the recent legislative session, DMA was exempted from rule making procedures for establishment of standards and medical necessity requirements; while other DMA topics are still subject to rulemaking. HB 381, Section 143B-147 (a)(1)(f) states that the Commission of

MH/DD/SA shall have the authority to adopt rules regarding the "Standards of public services for mental health, developmental disabilities and substance abuse services."

In addition, 143B-147(a)(1)(b) further states that "Operation of education, prevention, intervention, treatment, rehabilitation and other related services as provided by area mh/dd/sa authorities, county programs and all providers of public services…." shall fall within the authority of the Commission of MH/DD/SAS. "Public Services" is defined as "publicly funded mental health, developmental disabilities and substance abuse services whether provided by public or private providers.

Reporting Periods

- Currently, programmatic edits and funding years are on different reporting periods and fiscal years. Data are reported and/or collected by state fiscal year, (July through June), by federal fiscal year (October through September), by waiver year (December through November) or established by approval date with the Center for Medicaid and Medicare Services (CMS) or by calendar year (January through December). These inconsistencies can cause extra administrative time to calculate data based upon the report being generated and can also cause misunderstanding of the data being reported.

- In addition, the timelines associated with the edits and rules increase the possibility of errors by providers, as they must remember what rules apply to the different reporting periods. For example outpatient utilization management criteria allow for 26 visits prior to authorization by the contractor. The authorization is based upon a calendar year; however budgeting is based upon state fiscal year.

Appeal and Grievances

- Due process rights for families and consumers may take different paths contingent upon Medicaid, Health Choice funding or state funding and whether the consumer is an active client of an area authority or of a private provider or is in a state facility or being served by a private provider.

- Medicaid law allows for appeal of any reduction, suspension, termination or denial of service through a local hearing or direct with the state. Currently, depending on the provider, the appeal may be handled either through DMA or DMH. If the reduction, termination, suspension or denial is a result of an action by the area program, then the appeal is to DMH. If the reduction, termination, suspension or denial is a result of action by the utilization management contractor, then the appeal is through DMA. Both situations may go directly to the Office of Administrative Hearings.

- GS 122C-151.2-4 outlines the appeal process for accessing the State MH/DD/SA Appeals Panel. This process allows for a contractor to appeal the decisions of the area/county program. However, if a contract was not executed, then an agency has no appeal rights through this process since the provider does not meet the definition of contractor as defined in 122C-151.4(a)(2). If the provider's complaint is about refusal by the area/county program to contract for services, this statute limits the provider's recourse. Through direct enrollment with the state,

contracts have not been executed; thus the contractor doesn't have a right to appeal through the local agency.

- GS 122C-151.4 (a)(5) defines client as "an individual who is admitted to or receiving public services from an area facility. The term "client" includes the client's personal representative or designee." Unless the person has actually been admitted to a program, thus becoming a "client," he or she does not have appeal rights for denial of service. Although this is further complicated by the issue of entitlement to appeal with Medicaid funding versus non-entitlement to appeal with state funding, it does not address the actions of determination regarding eligibility of or referral to receive service. Examples include requests to receive services from an independent practitioner rather than the area program or accessing the six early intervention visits as allowed under Medicaid or Health Choice where area programs are not participating. The appeals process also does not address reduction of funding for a client who is receiving services.

- GS 122C-151.2-4 also only deals with services provided to the client by area/county programs. As more services are provided directly by private providers as required by GS 122C-141, what will be the appeal mechanism and to whom shall the client appeal? What is the appeal process for independently enrolled providers?

- The MH Reform bill requires a study and recommendations for the Advocacy and Ombudsman Program. Client rights and human rights rules will need to be revised accordingly. This includes but is not limited to the establishment of Client Rights Committees by provider agencies or as a function of the LME for providers serving the geographical area.

- Complainants must have access to a state review beyond the provider or area/county program level. Legal authority of the State Panel (122C-151.4) or grant review process should be expanded as allowed in HB381 (122C-112.1(29).

<u>Uniform Portal and Single Portal</u>

- GS 122C-132 outlines the requirements for single portal of entry and exit of mh/dd/sa services. This statute is in conflict with the MH Reform Bill, Section 1.2 (a), 122C-3(11) Uniform Portal Process and 122C-102(8) Implementation of uniform portal process. New statutory requirements will need to be established once uniform portal criteria are agreed upon. These statutes must be consistent and coordinated with the policies regarding independently enrolled providers and the results of monitoring.

- ICF-MR/DD eligibility is determined through an authorization process with DMA, through their contractor EDS. This process is in conflict with GS 122C-132.1, single portal of entry and exit determination for public and private services for individuals with developmental disabilities. Eligibility must recognize co-occurring disorders and not penalize eligibility when mental health or substance abuse challenges are present along with developmental disabilities.

<u>Emergency Services and placements</u>

- Area programs and local hospitals have obligations to deal with emergency situations. Current rules and statutes are unclear as to the extent of authority and responsibility and the result is

over-utilization of emergency rooms, extended duration of time before clients are seen or receive placement and utilization of practices that exacerbate the presenting problems or symptoms that may result in unnecessary use of restraints or restrictive interventions.

- Service authorization for residential placement requires documentation ordering the service prior to the actual placement. In instances where placement occurs after hours in non-hospital based facilities, documentation can be delayed or incomplete. Lack of the documentation causes the provider to not be compensated for the actual services provided.

- Transition planning for the consumer's care must be a requirement of the use of emergency services.

Funding

- 10 NCAC 14C does not reflect current practices, nor does it address county operated programs. Examples of the changes required include: 1) elimination of Thomas S, Carolina Alternatives and Willie M references, 2) description of financial monitoring reports, 3) update of settlement procedures with Medicaid and non-Medicaid funds, 4) administrative maximums and allowances, 5) procedures for payments as a result of IPRS implementation, and 6) update of specialized funding and unit cost reimbursement.

- A 1395 transfer allows for funding to follow the person upon discharge from a state operated Mental Retardation Center if the placement is in a community based ICF-MR program. This prevents the exploration of other alternative residential or support options and does not support self-determination and person centered service provision.

- Area programs are allowed to establish private, non-profit foundations that provide direct services to clients and families. There are no limitations placed on the area/county program regarding the use of state or federal funding in the establishment of these foundations.

- GS 122C addresses cost reports for the area/county programs; however, it does not speak to cost report submission by the private provider to the state or to the relationship of submission of such reports to the LME as outlined in the local business plan. Furthermore, certain providers submit reports directly to DMA while other providers submit cost reports to the DHHS Controller's Office. Requirements must be clearly defined for independently enrolled providers.

  A provider may actually submit multiple cost reports to multiple DHHS agencies for rate setting. Although significant work and progress has been made on a unified cost report, the efforts must continue; and the results must be placed in rule/statute.

  Settlement and auditing of cost reports has been limited to sampling or by type of private providers by DMA and to the area programs by DMH, DMA or DHHS Controller's Office. As more services move to the private sector, additional cost reports and audits will be required. Authority and monitoring procedures will need to be established that are similar to the issues being addressed by programmatic/physical plant/outcome monitoring.

- Fund balance requirements need to be established for the LME. The requirement should be placed in rule/statute.

- The current funding practices were originally developed when service delivery was primarily a facility-based model. As the participant-driven system develops, funding and accountability mechanisms must also be revised and updated to support the new service delivery model.

- Rules and procedures for rate setting (Medicaid and non-Medicaid) should be the same. The process for establishing the rates should be placed in rules. Rates should take into account all reasonable cost for the delivery of the service, and the rate should be established to support the models and practices endorsed by the state plan and disability areas.

- G.S. 122C-142.1(f) establishes and limits the fee for DWI assessment to $50.00. The statute should not cite an actual fee amount since rates and costs should be adjusted accordingly.

<u>Licensure and Service Definitions</u>

- For licensure purposes, a child is defined through age 18; however, under Medicaid child services are defined through age 21. Under IDEA requirements (special education) services may also be provided through age 21. In order to better interface across agencies and systems, ages birth through 21 need to be examined regarding access and system eligibility. This conflict causes requests for waivers from rules, changes in service delivery due to funding restrictions and lack of service transition planning.

- Currently not all services are subject to licensure. Twenty-Four (24) hour and day/night services require licensure, while some periodic services (outpatient) require licensure and other periodic services do not. An example is CBS (Community Based Services). As community services expand, and more wraparound services are utilized, minimum requirements will be established for all types of services.

- Licensure categories do not align with Medicaid service definitions or Health Choice.

- The definition of a facility, as defined by 122C-3(14), will need to be changed to be consistent with the terminology of the State Plan and to support the goals of system reform.

- 14V.0501 identifies area program required services. The list is not reflective of best practices or evidence-based service delivery. For example, ACT Teams (Assertive Community Treatment), a researched and proven best practice, are not required in every catchment area. Housing, transportation and employment options are limited or not referenced at all. Interpreter or translation capacities are not required services. Developmental day programs remain a required service even though the practice is to provide care in inclusive programs to the extent possible.

- Service definitions (Medicaid and non-Medicaid) do not support treatment approaches and service philosophy as recommended in the State Plan. Definitions are based on acute medical necessity criteria, are facility based, are limited to direct one to one service and do not support promoting independence, but rather encourage dependence. For example, billing is allowed only

when a face to face intervention is occurring. However as part of services, "down time" is needed to judge effectiveness of treatment and may be required in order to prevent relapse or to maintain stability.

Researched Integrated Treatment models for adult and youth with multiple disabilities places a strong emphasis on the stage Engagement. This most time consuming stage for appropriate treatment matching currently does not have a definition or fund code until more active treatment is developed for the family/individual

Service definitions are prescriptive in process and standards and are not outcome based. The definitions are not based upon the clinical care guidelines, tool kits, best practices, recovery models, self-determination, or system of care approaches.

The Medicaid State plan covered services, type of provider and location of services will need revisions to meet state plan recommendations. Examples include billing of services in locations other than private offices or area programs, for example, in schools. In addition, alignment is needed with Carolina Access II and III.

A service definition is needed for HIV Early Intervention and Outreach, all models of respite, and Six Early Intervention visits prior to diagnosis as provided under Health Choice and Medicaid.

- Admission and discharge rules must be revised to reflect changes since abolishing regional offices, service coordination responsibilities of the LME, target populations in state facilities, responsible state facility and timeframes as outlined in the State Plan and requirements of the local business plan. 10 NCAC 15 A, General Rules for Hospitals, 10 NCAC 16A, General Rules for Mental Retardation Centers, and 10 NCAC 17A, General Rules for Alcohol and Drug Treatment Centers, 18E Balanced and Integrated Programming, 18S Wright School need to be revised, eliminated and/or combined with other rules.

- Certificate of Need (CON) is required for the establishment of community residential substance abuse services. CONs are not required for mental health or developmental disabilities. The requirement should be removed for substance abuse services.

- Technology is one of the primary links of communication and reporting. Architectural structure and Internet access should be linked to direct enrollment and licensure.

- 14G.0102 and 14P.0102 both define "Neglect" and reference back to GS 122C-4 and 122C-53(f). Neither GS reference contains the definition of neglect as written in 14P or 14G.

  In addition, the definition of neglect used by DSS and the definition used by DMH/DD/SAS and DFS is different. This difference in the definition can cause a provider to be guilty of "neglect" by one regulatory agency but not by the other. This allows the provider to continue to provide services under one funding source, but not the other; thus allowing the provider to continue to provide care.

- The State Plan includes the provision of selected and indicated substance abuse prevention services. Science based, outcome driven models will be utilized for the service delivery and medical record documentation will need to be established to track the services as well as participant outcomes. This will need to be coordinated with the Service Record Manual revisions.

Miscellaneous

- Definitions in 122C do not match definitions in the State Plan glossary or do not support the recovery models, System of Care or integrated service planning, community based family centered models, self-determination models, or person centered planning. The definition of facility as defined in 122C-3(14) is an example of the conflict.

  Definitions do not reflect definitions of target populations as defined in the state plan or core functions. Language used in statutes or rules is not reflective of language used in state plan or in current practices.

  List of definitions is not inclusive of all types of services provided. For example, the definition of TASC (Treatment Alternatives for Street Crimes) or System of Care are not included. Definitions need to be reviewed across disabilities and ages.

- Liability insurance is not a requirement for direct enrollment with the DMA or with the local management entity (LME); however, the state has statutory requirements for all contractors to have liability insurance as a condition of contracting.

- Rules will need to be established and modified to reflect the staff competencies, registry and other components recommended in the State Plan Education, Training and Staff Competency document.

- More services will be provided by the private sector and the state will retain responsibility of ensuring adequate capacity to meet the needs of the community if the private provider faces bankruptcy or terminates the contract. 122C provides statutory guidance for dissolution of area or county program but does not provide any guidance or direction with the private sector.

- Current rules for monitoring and accreditation are duplicative and ambiguous regarding the role of DFS, DMH, DMA, DSS, national accrediting bodies and the local program. The monitoring subgroup will make specific recommendations regarding the clear delineation of responsibility and processes to be followed by the state and local entities. Monitoring functions should recognize facility and non-facility based services and should strive to ensure safety and quality of services.

- The State Plan adopts a System of Care approach for the delivery of child mental health services. This approach requires joint decision making by childcare agencies and establishes local community collaborative and teams. As this approach is implemented, issues regarding liability for the LME and for families have surfaced and current statutes are in conflict with practice

- DMA's Provider Enrollment Agreements do not match 122C requirements or State Plan recommendations.

- The developed standardized Memorandum of Agreement (MOA) between the provider and the LME will be placed in rule or statute.

- Rules will need to be established for Local Business Plans, approval criteria and provision of services by area/county programs

- A statewide-standardized fee schedule needs to be in rule or statute.

- GS 90-99 needs to be modified to include the republishing of the schedule of controlled substances through electronic means. The use of technology should also be examined in all aspects of practice and rules/statutes modified to allow appropriate online capability.

- 10 NCAC 14C is a mixture of rules for area programs, state facilities and other human service agencies. The content should be separated accordingly and definitions, citations deleted as appropriate. For example, 14C.0104 still refers to Willie M services.

- 10 NCAC 1K establishes the Minimum Administrative Standards for Local Human Service Programs. This includes personnel standards, data system standards, fiscal standards, contracting standards, planning and programmatic standards, etc. These standards have not been revised since 1989.

- Client rights are addressed in separate NCAC designations, for community and for state facilities. Although community and state facilities may need to have different rules in certain situations, consistency and contuinity of rights for clients is essential and fundamental to State Plan implementation.

- In whole or part, 10 NCAC 14, 15, 16, 17, 18 need to be reorganized and combined and republished for easier accessibility for providers and the general public. Standards and requirements are in several manuals and under different rule designation depending on the Division. For example, Medicaid or Health Choice rules are not found in the above mentioned rule designations.

- Guardianship statutes, rules and policies need to be reviewed and revised in order to endorse a participant driven system. Specific issues have arisen with respect to the guardian's role (especially that of a public guardian such as area program, DSS) in the implementation of Olmstead. Area Programs may be appointed as the guardian of a consumer. Concerns have been expressed regarding their ability to be objective when they are responsible for developing treatment options, authorization of services and giving permission for the person.

- Special Assistance funding is statutorily limited to where the person can live and receive special assistance funding. The requirements of location for access to funding should be reviewed for applicability in terms of flexible funding to support people with disabilities to live in the most

integrated setting in the communities, in compliance with Supreme's Court Olmstead decision.

- State personnel rules governing the state and local personnel practices should be reviewed and modifications made in order to support best practice, participant drive system and to maintain a competent work force as outlined in the State Plan.

- Commitment Statutes need to be reviewed to identify possible conflict between SB 859 and "dangerous to self and others" language in the commitment statutes. This conflict could ultimately impact on access to appropriate services for people with developmental disabilities who are also suicidal.

- GS 122C-112(a)(15) death reporting of perspective or confirmed Thomas S class members was repealed as a result of resolution of the Thomas S lawsuit and passing of HB 381; however, 10 NCAC 14V.7100 Thomas S Death Reporting and Review remains active under Administrative Code.

- The recent work on credentialing and privileging to establish Qualified Professionals for each disability shall be amended to include Qualified Substance Abuse Prevention Professional as recommended and approved in the State Plan.

- The Certified Clinical Addiction Specialist (CCAS) is a master's level credential offered by the NC Substance Abuse Professional Certification Board (NCSAPCB). The NCSAPCB grants deemed status to Licensed Social Workers, Licensed Psychologists, and Licensed Professional Counselors for those individuals who have specialty certification in substance abuse and grants the CCAS to individuals with such credentials. Given this credentialing process, CCAS should be included as eligible for Independent practitioners' status with Medicaid.

- Area Programs and Carolina Access Physicians are allowed to make referrals to independent practitioners for certain types of services; thus allowing for direct billing. However, psychiatrists, the physician whose specialty is mh/dd/sa services is not allowed to make such referrals.

- Coordination and review of other departments' rules and policies such as Department of Public Instruction, Department of Juvenile Justice and Delinquency Prevention and Department of Corrections must continue.